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Approved by Council
March 1989

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District-level services for drug takers

The role of the general psychiatrist*

The advent of HIV infection among injecting drug misusers reinforces the need for the rapid expansion and increased availability of a comprehensive health care service for drug misusers.This will require development of a broad range of local services, with the capacity to respond quickly to new referrals, and to arrange long-term supervision. Regional services will continue to provide treatments and to offer advice, support and training, but cannot offer therapy to all drug users.

A service must be available in every district. District Health Authorities must recognise and accept their administrative and financial responsibilities for this provision. The Central Funding Initiative and subsequent earmarked fundings (HC 83/13 and subsequent) have in many districts achieved successful expansion of the non-statutory and *non-medical* components of drug services (e.g. voluntary agencies and community drug teams). However, this expansion has often not been accompanied by an adequate development of local specialist medical input, which should include provision for prescribing.

In developing adequate provision, every district requires a consultant psychiatrist, with identified responsibility for drug services and who has designated sessions for this purpose. In some districts it may be more realistic for this consultant additionally to hold responsibility for alcohol services, for which a separate allocation of sessions are required. The Royal College of Psychiatrists has recommended that in an average district there should be at least four sessions of consultant time specifically set aside for drug services or four sessions set aside for drug and alcohol services. The general policy from the Department of Health is that District Health Authorities should ensure that adequate consultant time is available for the provision of a comprehensive service to the drug using population and that this should be gauged accordingly to local circumstances.

It is likely that there will be a need for at least two identified drug sessions within an average district, that more are required in districts with a high prevalence of drug misuse and in large districts, and that the number of sessions will increase in step with a general expansion of consultant posts.

At district level, the consultant with identified sessions would expect to be a member of the District Drug Advisory Committee, and to be involved with district management and other relevant agencies (local authority and non-statutory agencies) in the planning and implementation of local drug services. The role of the consultant would include advising on the adequacy and appropriate nature of both statutory and non-statutory provisions (including community-based facilities), planning and service input into provision for HIV and AIDS, and continued monitoring and development of services as new needs arise.

Within every district access to the following components of comprehensive health care for drug takers should include:

(1) **Management of physical complications**
Management of acute intoxication, overdose, pregnancy associated with drug taking and other medical complications is primarily dealt with by accident and emergency departments and general medical wards including obstetrics.

*Discussion document issued on behalf of the Substance Misuse Section of the Royal College of Psychiatrists.

https://doi.org/10.1192/pb.13.6.322 Published online by Cambridge University Press

The specialist psychiatric services should be involved in devising appropriate operational policies for the management of drug dependent patients within these non-psychiatric services, and in arranging for subsequent support and treatment.

(2) **Counselling** is the central process of treatment. During the early stages of treatment counselling aims to develop and strengthen motivation. Later there is an emphasis on the prevention and curtailment of relapses.

(3) **Withdrawal** should be provided at district level both for out-patients and in-patients. Rapid out-patient detoxification will often be insufficient to help the drug addict achieve stable abstinence, and facilities should be available for the provision of slower out-patient detoxification and in-patient treatment. These measures require appropriate specialist psychiatric out-patient sessions and an identified allocation of *easily accessible* beds under the charge of the district consultant. Where possible the beds should be within one ward, to enhance management expertise of medical and nursing staff.

(4) **Longer-term treatment plans** will be required for some more entrenched drug addicts. Drug (and alcohol) dependence are often chronic and relapsing disorders. For the drug user with accumulated social problems, long-term management is required for the benefit of personal and public health. This should include within its aims the reduction in the risks (such as HIV infection) to and from the drug taker posed by injecting and sexual activity, as well as reduction in the extent of continued criminal activity arising from the distribution and financing of drug use. The availability of both withdrawal and residential rehabilitation is essential. However, as an intermediate goal a period of stabilisation can be a necessary option pending a further concerted attempt at withdrawal. This will include the extended prescribing of substitute drugs combined with the realistic provision of social supports including accommodation. There may be particular benefits from continued contact with drug users who are at risk of HIV infection so as to allow continued monitoring of their medical condition and the possible emergence of HIV disease.

Thus the operation of the service should include considerations of maximising initial contact, subsequent follow-up and treatment compliance. If a period of extended prescribing is undertaken appropriate safeguards regarding both diversion of prescribed drugs frequent reviews are necessary (see below).

The district consultant psychiatrist with identified sessions for drug misuse requires junior medical staff, paramedical staff, administrative support, and an established link with a general physician who has AIDS responsibility. The consultant psychiatrist must accept responsibility for providing expert input into the planning of services and for advising on the appropriateness and availability of social support. The latter can be provided direct by the NHS (e.g. community drug teams), by other statutory organisations such as local authority social services or the probation service, or contractually through the NHS by voluntary organisations.

Regional context

It is important that district drug services exist within an appropriate climate of back-up facilities in their region and elsewhere which may be employed when necessary. These include residential rehabilitation houses (discussed in the next section) as well as regional drug dependence units. The latter are available for advice and for treatment of patients whose management seems more than usually complicated or who require specialised approaches which are not available within the district.

Residential treatment for the continued care of detoxified addicts must be readily accessible. This can be provided in a number of ways – by district, regional or sub-regional specialist NHS beds; within medium term rehabilitation (such as that involved in the 'Minnesota programme'); by longer-term rehabilitation in 'Concept' and other therapeutic communities. Some drug users have serious long-term psychological disabilities which especially require residential treatment.

Practical considerations – clinical

A number of specific issues must be addressed in the provision of district services for drug takers.

Assessment

Full multidisciplinary assessments must be available both for the newly presenting problem drug takers and at frequent intervals for patients in extended stabilisation, including those being primarily managed by (and receiving prescriptions from) general practitioners. Assessment must include laboratory testing both for drug analysis (e.g. in urine) and for the investigation of medical complications. A medical examination and psychiatric assessment are also essential, especially following the identification or possibility of HIV disease.

Drug provision

There are now a range of pharmaceutical preparations available for the stabilisation, withdrawal,

https://doi.org/10.1192/pb.13.6.322 Published online by Cambridge University Press

and abstinence reinforcement of drug users. These include not only methadone, but possibly other opiods, clonidine, and the blocking drug naltrexone. Health Authorities should allocate funds to cover the costs, including the dispensing costs of drugs. Prescribing of these drugs by general practitioners is possible with the partial safeguard of daily dispensing of addictive drugs by retail pharmacists. The provision of prescribed drugs is contingent upon compliance with abstinence from illegal drugs and modification of social behaviour. Monitoring of compliance requires frequent counselling and urine testing. Immediate compliance by a patient is often an unrealistic expectation but the repeated intake of illicit drugs hinders a crucial purpose of prescribing which is to lead the patient away from a life style, including social contacts that involves drug misuse. Joint care between the district consultant and the general practitioner may be a useful approach, particularly for more stable drug users.

Community Drug Teams

In many districts, Community Drug Teams have been, or are being, established. Although the staff mix and working methods vary considerably, they usually provide easier access to services for drug takers, and also provide a direct supporting service to drug takers, as well as providing advice and support to general practitioners and general psychiatrists who are providing treatment to drug takers in the local area. It may be an efficient use of general psychiatrists' time for the service to drug takers to be provided in conjunction with such locally-active Community Drug Teams and it should be possible to improve both quality and quantity of service provided in this way.

Goal-setting and review

Goal setting should identify individual goals which are realistically achievable and personally relevant for the patient, while continuing to promote the attainment of long-term goals which may be unrealistic in the short term.

If an intermediate goal(s) other than abstinence has been identified, it is essential that frequent reviews of progress are undertaken. When the patient is primarily managed by a general practitioner, the consultant psychiatrist should advise on appropriate goal setting and should provide a service of regular assessment of progress and of treatment plans.

Drug diversion

If a decision is made to prescribe for the longer-term or chronic (and often self-labelled as hopeless) drug addict who is heavily involved in the illegal drug scene, then supervised consumption of medication will have to be considered with due attention to the needs for security of drugs and for ensuring the safety of supervising staff. Consumption of prescribed drugs under supervision takes place on NHS premises and in certain pharmacies. Provision already exists for NHS hospital practitioners to use special prescription forms FP10 (HP) (ad); and this has recently been extended in a modified form to general practitioners (FP10(MDA)).

Shared care with general practitioners

General practitioners are able to assist in the care of such patients, thereby relieving the specialist services which can concentrate on the care of more difficult patients or more specialist treatments. In many districts there are now Community Drug Teams which may include staff from various disciplines – for example a community psychiatric nurse, a social worker, a psychologist. These staff will often be able to provide practical advice and assistance in the identification of an appropriate care plan and its subsequent implementation and monitoring. The use of FP10(MDA) prescription forms enables the prescribing general practitioner to instruct the pharmacist to dispense on a daily or less frequent basis as indicated, up to 14 days' supply.

It is essential that regular reviews are undertaken by specialist staff to ensure that extended withdrawal and stabilisation regimes have not become by default indefinite maintenance prescribing. The model of 'shared care' as implemented in obstetrics would seem worth development.

Prison/remand

The consultant psychiatrist, in the context of the District Drug Advisory Committee, should review the facilities needed to provide reports for people remanded by the Courts on drug related charges. This might include remand to in-patient care, but use of local bail hostels can be discussed with the local probation service.

Consideration in consultation with probation and prison authorities should also be given to input both by the consultation or other drug personnel to the education and counselling needs of drug offenders held in local prisons and remand centres. This is particularly relevant to HIV harm reduction strategies to pre-discharge-advice (including caution of the danger renewed high drug intake following loss of tolerance during custody), and continued aftercare.

Practical considerations – organisational

Scale of services required

Urban centres are likely to have several hundred potential patients. Public health needs require a

https://doi.org/10.1192/pb.13.6.322 Published online by Cambridge University Press

high proportion of these to be in contact with the treatment services.

Planning must take account of the necessity of providing continued access for new patients without undue delay, while recognising that many patients will require recurrent or long-term periods of therapy.

In rural areas, which often entail the provision of services in widely disseminated small towns, particular arrangements may be necessary. The measures may include treatment by general mental health professionals, who would receive guidance from specialist district and regional services.

Care outside NHS facilities

Access to longer term rehabilitation depends upon the close working relationship from the specialist NHS services. Co-operative action with health authority and local authority social service departments is needed to provide core funding for non-statutory projects, with top-up funding through the local authorities for individual drug users who require residential rehabilitation in hostels.

Record keeping

It is important that record-keeping both in statutory and non-statutory drug agencies is of a high standard to allow evaluation of the service and to provide an early awareness of new drug problems. Data must be stored in a form that permits comparison between projects or districts so as to permit meaningful regional analysis of this information. This will require adequate and precisely allotted secretarial and clerical support for psychiatric and paramedical staff.

Training long-term arrangements

Many kinds of staff require expanded provision for training. There is a shortage of senior registrars in psychiatry who are adequately trained to take over consultant responsibility for drug dependence services. Each rotational scheme for senior registrars should contain an approved placement for substance misuse that includes experience with drug misusers. Registrar rotations should also provide shorter-term experience and instruction in the assessment and care of drug misusers. For further information on senior registrar training requirements see Report from Royal College of Psychiatrists, 1989.

The district drug consultant, in collaboration with regional drug services, should ensure that training is provided for a wide range of health and other professions, in particular:

general practitioners: in conjunction with post-graduate deans with university departments of general practice and with regional advisers of the Royal College of General Practitioners. Clinical assistant or hospital practitioner appointments provide a useful means of developing a pool of general practitioners.
specialist drug nurses
social workers
probation officers

The need for special funding that is additional to the existing local training budgets for health personnel, social workers and probation officers should be agreed and implemented by the respective budget holders.

Training – urgent action required

Until there is an adequate number of senior psychiatric registrars with appropriate training, there is an immediate need for some general psychiatrists to divert identified sessions to drug misuse. They require a period of attachment (whole-time or part-time) to an established drug dependence service. The expansion of treatment services for drug dependence, including the diversion of general psychiatrists requires additional general psychiatric consultant posts.

Approved by Council
March 1989

The Membership Examination

We have been asked by the Court of Electors to remind all candidates who present themselves at the College's Examinations that they are expected to observe scrupulously the normal examination conventions at all times. Two specific points need particular attention:

(1) *The Written Examinations*
Candidates are expected to take care that they follow precisely and promptly all instructions given by invigilators. In particular, they should stop writing *immediately* they are told to do so, even if this should mean a sentence remains incomplete. Any candidates

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